

**Park Avenue Pediatric Dentistry**  
Dentistry for Infants, Children and Adolescents

Date \_\_\_\_\_

PATIENT INFORMATION

Patient's name: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_  
City, State Zip Code

Mother's Name \_\_\_\_\_ Occupation: \_\_\_\_\_ Work # \_\_\_\_\_ SS# \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work # \_\_\_\_\_ SS# \_\_\_\_\_

Cell \_\_\_\_\_ Email \_\_\_\_\_

How would you like to be contacted \_\_\_\_\_ Via e-Mail \_\_\_\_\_ by phone

Sibling(s) \_\_\_\_\_ Age(s): \_\_\_\_\_

Sibling(s) \_\_\_\_\_ Age(s) \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Emergency Contact(s): \_\_\_\_\_

Who is responsible for payment of dental treatment? \_\_\_\_\_

Patient's Pediatrician: \_\_\_\_\_

Last Physical Exam: \_\_\_\_\_ Nanny/ Sitter's Name: \_\_\_\_\_

DENTAL HISTORY:

Is patient having any dental discomfort? \_\_\_\_\_ Bleeding gums? \_\_\_\_\_

Has patient ever had previous dental treatment? \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Any blow or injuries to teeth or face? \_\_\_\_\_

Name of orthodontist? \_\_\_\_\_

Is the patient a mouth breather? YES NO

Does any member of the family have missing teeth? \_\_\_\_\_ History of decay? \_\_\_\_\_

How does patient behave at pediatrician? \_\_\_\_\_

How do you think your child will react toward dental treatment? \_\_\_\_\_

Does your child have any oral habits ---- Circle: Thumb Finger Pacifier?

Is patient being breast fed? \_\_\_\_\_ Using a bottle \_\_\_\_\_ Contents: \_\_\_\_\_

If not, at what age was bottle/breast discontinued? \_\_\_\_\_

**MEDICAL HISTORY:**

***Has your child had any of the following? Please check all that apply.***

|                          | Yes | No |                              | Yes | No |
|--------------------------|-----|----|------------------------------|-----|----|
| Visual Disorders         | —   | —  | Rheumatoid Arthritis         | —   | —  |
| Hearing Disorders        | —   | —  | Blood Disorders              | —   | —  |
| Ear Infections           | —   | —  | Anemia                       | —   | —  |
| Sinus Problems           | —   | —  | Prolonged Bleeding Disorders | —   | —  |
| Asthma                   | —   | —  | Diabetes                     | —   | —  |
| Tuberculosis             | —   | —  | Thyroid Problems             | —   | —  |
| Respiratory Problems     | —   | —  | Neurological Disorders       | —   | —  |
| Rheumatic Heart Disease  | —   | —  | Convulsions/ Seizures        | —   | —  |
| Heart Murmur             | —   | —  | Fainting                     | —   | —  |
| Cardiac Problems         | —   | —  | Tumors                       | —   | —  |
| Liver Disease/ Hepatitis | —   | —  | Hyperactivity                | —   | —  |
| Renal/ Kidney Disease    | —   | —  | Learning Disability          | —   | —  |
| Intestinal Problems      | —   | —  | ADD/ ADDHD                   | —   | —  |
| Muscular Disorder        | —   | —  | Delayed Speech               | —   | —  |
| Coordination Problems    | —   | —  | Major/ Minor Surgery         | —   | —  |
| Oral Herpes              | —   | —  | Hospitalizations             | —   | —  |
| Special needs            | —   | —  |                              |     |    |

**Medications:** \_\_\_\_\_

**Medication allergies:** \_\_\_\_\_ **allergies:** \_\_\_\_\_

**Latex Sensitivity:** \_\_\_\_\_

**Has patient had any disease/ illness not mentioned?** \_\_\_\_\_

**Is there anything at all you think we should know about your child?**

\_\_\_\_\_

Was the term of your pregnancy and birth normal? \_\_\_\_\_

I herby consent to dental procedures and techniques which the dentist, Dr. Pilla, Dr. Lambert, Dr. Haim and Dr. Spear in attendance deem necessary for the treatment of the patient. I authorize the dentist to provide any information to the other doctors for purpose of consultation. I understand that prior to any treatment I will be advised about it by the dentist or hygienist, which I may ask questions concerning it; and that I may revoke this consent before treatment is provided. I understand that I may ask for a full recital of any or all risks attendant to the care of the patient.

**Date:** \_\_\_\_\_

**Signed:** \_\_\_\_\_

**Parent or Guardian**

**Date:** \_\_\_\_\_

**Signed:** \_\_\_\_\_

**D.D.S.**